

# CLINICAL QUARTERLY



Menlo Park/Palo Alto \* Boston \* Honolulu \* West Haven \* White River Junction

## REDUCING CAREGIVER BURDEN AND PSYCHOLOGICAL DISTRESS IN PARTNERS OF VETERANS WITH PTSD

Patrick S. Calhoun, Ph.D. and Tim Wampler, L.C.S.W.



Patrick Calhoun

The impact or burden of caring for persons with chronic illness was first examined in the 1960s in studies of family members caring for relatives with mental illness (1). Since then, caregiver burden has become an increasingly recognized and examined construct. While the majority of research examining caregiver burden has focused on caregivers of older adults and patients with Alzheimer's dementia, recent research suggests that caring for an individual with chronic posttraumatic stress disorder (PTSD) is associated with significant burden and may have deleterious effects on caregiver psychological adjustment (2,3). Caregiver burden can be understood as both the objective burden associated with caring for an individual with chronic illness (e.g., financial problems, disruption of family life, strained neighbor relations) as well as the subjective burden (e.g., caregiver responses, affective responses) associated with these demands (4). Caring for a family member with chronic illness has been associated with both poorer psychological adjustment and physical health (5).

PTSD is believed to be chronic in approximately one third of people with a lifetime history of the disorder (6). There is clear evidence that patients with PTSD experience both significant intrapersonal and interpersonal difficulties including problems with communication, self-disclosure, sexual intimacy, family cohesion, hostility, aggression and interpersonal violence (7-10).

These difficulties have led some clinicians and researchers to conceptualize PTSD as a long-term disease that places stress on caregiving partners (11). Indeed, partners of veterans with PTSD must face a number of significant stressors associated with caring for a partner with a chronic disease. These stressors may include crisis management, symptom management, social isolation, financial problems, strain on the family system, and adjustment to the course of the disease (12).

There is increasing evidence that PTSD and associated behavioral problems have a negative impact on those living with patients with PTSD. In a study comparing veterans with and without PTSD, high levels of stress and adjustment problems were found in the majority of partners of patients with PTSD. Almost half of these women reported having felt "on the verge of a nervous breakdown" (13). In one of the first studies designed to specifically examine caregiver burden in partners of patients with PTSD, Beckham and colleagues documented that PTSD symptom severity was both cross-sectionally and prospectively related to caregiver burden and partner psychological distress (1).

Similarly, more recent research examining the associations between caregiver burden, PTSD and associated difficulties (e.g., hostility, depression, health



Tim Wampler

Authors note: The views expressed in this paper are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs

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## FROM THE EDITOR...

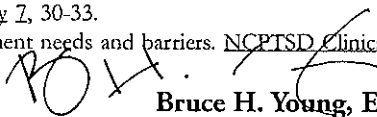
A primary reason for publishing the *Clinical Quarterly* is to disseminate innovative ideas that address the challenges commonly faced by VA and other PTSD treatment providers. The two feature articles of this issue respectively describe new clinical approaches that VA practitioners are using to increase veteran social support and meet the growing demands for PTSD treatment services in an era of diminishing resources.

While social support plays a vital role in the quality of life for virtually everyone, for many PTSD diagnosed veterans, having or developing close supportive relationships is exceedingly difficult, and many such veterans are socially isolated, divorced, or have severely strained personal relationships (1). It's probably fair to say that VA PTSD-related treatment that aims to enhance social support (by improving such skills as communication, anger management, conflict resolution, etc.) is often conducted within a group of veterans or with the veteran alone. However, new treatment strategies are emerging that involve family members as another means to help better social support. In previous issues of the *Quarterly*, Erika Curran (2) presented a "family approach" to address the affect of a fathers' PTSD related symptoms on their children, and Judy Lyons and Leslie Root (3) described their strategies to increase family involvement in treatment. In this issue, Pat Calhoun and Tim Wampler share the approach they have developed to identifying and addressing persistent family relationship problems in their effort to help improve the quality of veterans' lives.

The effort to increase the utilization of PTSD screening measures by primary care providers and others is successfully moving forward (see this issue's New Directions column). However, as PTSD treatment services receive more referrals, the increase is occurring at a time when such treatment services are losing resources. In our second featured article, Evelyn Sandeen and Ella Nye describe how their outpatient PTSD clinical program has been restructured to best provide the greatest number of veterans the right care, at the right time by assessing several domains related to treatment readiness. In sum, both featured articles describe excellent examples of the types of creative and pragmatic clinical innovation being implemented by VA practitioners to meet the challenge of providing the highest level of care to our veterans.

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## REDUCING CAREGIVER BURDEN

complaints, hostility, interpersonal violence) has shown that compared to partners of combat veterans without PTSD, partners with a spouse with PTSD, experience significantly higher levels of caregiver burden, anxiety and depression (2).

Relatively little research has examined which symptoms and behaviors are most strongly related to caregiver burden among partners of patients with PTSD.

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**Adequate time must be allotted for the initial contact with caregivers, as we have found many partners are breaking the silence of the impact of their spouse's PTSD symptoms for the first time.**

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We have found, however, that the presence and level of interpersonal violence may be an important factor in levels of burden and spouse psychological adjustment (2). Veteran initiated violence may lead to acute crises (e.g., increased involvement with law enforcement, loss of employment, exacerbation of PTSD symptoms, medical problems) that contribute to increased burden among caregivers. Partners and family members may actually become victims of violent assaults. Veterans with PTSD are at increased risk for the perpetration of domestic abuse (13). Results from the National Vietnam Veterans Readjustment Study found that as many as one third of veterans with PTSD had assaulted their partners in the past year (14). The rates of domestic violence are likely to be even higher among treatment seeking veterans with PTSD (15).

Given high rates of domestic violence and a strong association between interpersonal violence, burden and poor psychological adjustment, clinicians must carefully assess for the perpetration of domestic violence. The frequency and severity of violence should be assessed through the use of multiple methods, e.g., clinical interview and validated self-report instruments such as the Conflict Tactics Scales (16), and multiple sources (e.g.,

partner reports). Thorough evaluation of violence is important to both ensure the safety of family members and to develop a treatment plan aimed at reducing violence (15). While anger management has been suggested as a critical component of PTSD treatment, there is a need for further research investigating its effectiveness at reducing aggression and the burden experienced by caregivers.

While we would suggest that ensuring the safety of family members is a critical first step in efforts at reducing caregiver burden, there is currently little research to inform clinicians what other steps should be taken in order to reduce burden among caregivers of patients with PTSD. Based largely upon reviews of the caregiver literature examining interventions aimed at reducing burden among family members of patients with chronic medical conditions including dementia (17-18), we currently apply a five component intervention strategy. These components are outlined in Table 1 and include Assessment, Education, Support, Counseling, and Case Management.

**Table 1. Components of an Intervention Aimed at Reducing Burden in Caregivers of Patients with PTSD**

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|--|
| <ul style="list-style-type: none"> <li>• <b>Assessment</b> <ul style="list-style-type: none"> <li>Level of burden</li> <li>Partner depression, anxiety symptoms</li> <li>Availability of social support</li> <li>Level of marital conflict</li> <li>Communication and problem solving deficits</li> </ul> </li> <li>• <b>Education</b> <ul style="list-style-type: none"> <li>PTSD symptoms and course</li> <li>Associated behavioral difficulties</li> <li>Signs and symptoms of caregiver burden</li> </ul> </li> <li>• <b>Support</b> <ul style="list-style-type: none"> <li>Enlist social support</li> <li>Support group</li> </ul> </li> <li>• <b>Counseling</b> <ul style="list-style-type: none"> <li>Stress management</li> <li>Couples treatment</li> </ul> </li> <li>• <b>Case Management/Referral</b> <ul style="list-style-type: none"> <li>Linkage with community resources</li> <li>Advocacy</li> <li>Referral to community mental health resources</li> </ul> </li> </ul> |
|--|

## CALHOUN &amp; WAMPLER

**Assessment**

We attempt to invite partners or other family members to our clinic early in the treatment of clients with PTSD. The involvement of significant others allows us to gather important collateral information that aids in the accurate assessment of the identified patient's PTSD symptoms and other difficulties, including substance abuse and interpersonal violence. Partner involvement also provides an opportunity to assess the level of burden experienced by the family. In order to assess burden and levels of anxiety and depression experienced by caregivers, we use both open-ended interview questions and standardized, psychometrically sound instruments such as the Burden Interview (19) and the Beck Depression Inventory (20). We also assess the level of relationship distress, communication and problem solving deficits, and the adequacy of social support available to caregivers.

Adequate time must be allotted for the initial contact with caregivers, as we have found many partners are breaking the silence of the impact of their spouse's PTSD symptoms for the first time. Similar to many of our patients who have not openly discussed their traumas for over 30 years, these initial interviews with caregivers are often emotionally laden. Often this initial assessment is therapeutic as caregivers feel a sense of relief after discussing their own feelings and concerns. After assessing the caregivers current functioning, we address their education, support or treatment needs.

**Education**

We begin to educate caregivers during our initial contact with them. The primary objective associated with our educational component is the normalization of symptoms associated with high levels of trauma exposure. A general overview of PTSD is provided, which includes a discussion of the potential impact chronic PTSD symptoms may have on the family system. Current treatment options are discussed, as is the possibility that patients may initially experience increased levels of distress before seeing treatment gains. It is important that caregivers understand the course of treatment, as many uninformed family members overtly sabotage treatment upon witnessing increases in distress in their partner. Furthermore, we attempt to normalize the many reactions caregivers experience while living with someone

with chronic PTSD, including confusion, anger and hostility, shame and guilt, depression, anhedonia, anxiety, social isolation, and marital distress.

**Support**

The role of additional social support for the caregiver can be invaluable in relieving the felt burden experienced by partners of veterans with chronic PTSD. Social support is provided in varying degrees depending upon the adequacy of the caregiver's social network and utilization of immediate resources. For caregivers with good social networks, we discuss how they might better mobilize support. For partners who are socially isolated, we discuss ways to increase their networks. The use of support groups can be particularly helpful to decrease social isolation and to normalize difficulties common to relationships destabilized by chronic PTSD symptoms. Clinicians need to be attuned to the barriers which complicate the receipt of adequate social support. We have found, for example, many caregivers are unable to attend routine daytime appointments due to work considerations.

**Counseling**

We have found high rates of anxiety and depression among caregivers of veterans with PTSD in our clinics (2). Many caregivers could benefit from individual treatment and are referred to various local community resources for further help. We currently offer a three session psycho-educational intervention that provides education about PTSD, common reactions to coping with a loved one's chronic PTSD symptoms, the negative aspects of prolonged stress, and stress management skills (including relaxation training).

In many cases, caregivers remain active in their partner's treatment through periodic joint sessions. Joint sessions help facilitate open and honest communication between family members, dispel cognitive distortions, and allow patients to practice efforts aimed at improving emotional intimacy. Often couples will be referred for formal relationship counseling to target communication and problem solving deficits.

One potential difficulty in efforts aimed at reducing caregiver burden is related to patient trust. Many veterans suffering from chronic PTSD are openly distrustful

## REDUCING CAREGIVER BURDEN

and may view the involvement of their partner in treatment as a threat. In order to foster an atmosphere of trust, the clinician must be careful not to alienate the client while attempting to outreach to his/her caregiver. Clinicians should discuss the potential benefits of having a caregiver involved in the treatment process.

### Case Management

Case Management as we define it, is the process by which clients and family are linked with valued and needed services and resources. Some of these resources include county service officers, local veterans organizations, county and state government agencies, and other DVA resources. Caregivers are often faced with financial, legal, and other difficulties that stretch their own coping resources. The clinician's active involvement as an advocate and liaison with local organizations can help reduce the objective burden associated with caring for an individual with chronic PTSD.

### Conclusions

While research examining caregivers of patients with PTSD is in its infancy, it seems clear that chronic PTSD symptoms are associated with significant burden and may have deleterious effects on caregiver psychological adjustment. Clinicians need to understand and directly address the impact PTSD symptoms and behavioral problems have on families and caregivers. Clearly, there is a need for further research aimed at identifying effective interventions that reduce the burden of caring for patients with posttraumatic stress disorder.

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Timothy P. Wampler, M.S.W. is a licensed clinical social worker and Mental Health Disaster Services Coordinator at the Durham VA Medical Center. He has served on the VA National Social Work Program and Evaluation Committee and is the former chairman of the POW Advisory Committee at the Durham VAMC. His clinical specialty and practice focuses on the assessment and treatment of anger, aggression and family discord among veterans with chronic, combat-related PTSD.

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## **National Child Traumatic Stress Network National Center for Child Traumatic Stress & National Center for PTSD**

Treatment centers from all over the United States have come together to form a new coalition, the National Child Traumatic Stress Network (NCTSN). The Network, which is currently comprised of 36 centers, is being funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and U.S. Department of Health and Human Services through a Congressional initiative. This Congressional initiative recognizes the profound, destructive, and widespread impact of trauma on American children's lives. Its purpose is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events.

The Initiative also created the National Center for Child Traumatic Stress (NCCTS) which will coordinate and oversee the Network. The Center is jointly directed by University of California Los Angeles and Duke University, two academic pioneers and innovators in the treatment of trauma in children.

The National Center for PTSD has consulted with NCTSN in two general areas: 1) providing advice on organizational structure and function; and 2) collaborative possibilities with respect to research, education, and consultative activities. With regard to future collaboration, discussions include integration with the PTSD Resource Center, common research protocols promoting longitudinal research on PTSD across the lifespan, and a collaborative educational and consultative approach to early intervention, as well as developing practice guidelines for adults, children and families for long-term treatment of PTSD.

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# NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.  
Executive Director, NC-PTSD



On October 7-8, the National Center held its third National Primary Care/Mental Health Conference in Washington, DC. This conference is the most visible component of our primary care initiative which has been a major priority of the National Center for the past five years. It exemplifies our emphasis on the rapid translation of science into practice and practice into science.

Greg Leskin, with the support of Fred Gusman and Joe Ruzek at the National Center's Education Division in Palo Alto deserves the major credit for the success of this conference. As a result of Greg's persistence and dedication, VA primary care and mental health practitioners have had the opportunity to consider integrated clinical approaches through which to improve overall treatment for veterans with PTSD. It is also notable that Greg was able to obtain funding entirely from private donors for this as well, as for both of the National Center's previous PTSD/primary care conferences.

Conference highlights included a keynote address by Dr. Robert Roswell, VA's Under Secretary for Health. Dr. Roswell's interest in integrated primary/mental health care dates back to when he served as Chief of Staff at the Birmingham VA Medical Center, where he oversaw one of the first integrated efforts to attend to the psychological as well as medical needs of Gulf War veterans.. Another notable participant in this conference was the U.S. Surgeon General, Dr. Richard Carmona, himself a Vietnam veteran. Dr. Mark Stanton, who directs VA's Primary Care program, was a very active conference participant along with Kirk Strosahl and Patricia Robinson who have been leading the field in the development and implementation of such integrated approaches. Finally, Scott Murray, Mary Scholen, and Catherine Vernon presented the very successful results of their integrated primary and mental health treatment program in VISN 2.

National Center activities in this area began almost ten years ago with scientific findings suggesting that people with PTSD are at a greater risk to develop medical illnesses than those not affected by this disorder. Paula Schnurr's work with veterans from the Normative Aging Study stands out as an exemplar of such research, having shown that veterans with PTSD are more likely to develop peripheral vascular disease and other medical problems than veterans without this disorder. Subsequent research on both veterans and civilian cohorts has confirmed such findings and drawn increased attention to the physical health problems and higher medical clinic utilization rates of veterans and civilians with PTSD.

Indeed, medical utilization data within both VA and civilian health care systems indicates that individuals with PTSD are much more likely to seek treatment from primary/specialty medical practitioners than from mental health professionals for PTSD-related and other physical complaints. Research by Terry Keane and Eva Deykin at the National Center's Behavioral Science Division in Boston, has shown that veterans with PTSD are much more likely to rank among the highest utilizers of medical services.

The obvious implication of such findings is the need to establish integrated primary/mental health care for veterans with PTSD and other psychiatric disorders. Two successful examples of such approaches have been developed by the National Center's Women's Health Science and Evaluation Divisions. The integrated model for female veterans, originally developed by Jessica Wolfe and currently under the direction of Eve Davison, Erica Sharkansky and Lauren Dever at the Boston VAMC, was one of the first successful programs of that kind within VA. The demonstration of superior clinical care outcomes shown by Benjamin Druss, Bob Rosenheck, and others at the West Haven VAMC, was one of the first published clinical trials in this area.

The Education Division at Palo Alto has accepted major responsibility for advancing the National Center's agenda to promote integrated care. Recent accomplishments include the construction of a reliable 4-item screening questionnaire for primary care settings by Annabel Prins, Rachel Kimerling, and others, and recent publication of a PTSD/primary care self study program, the "Veterans Health Initiative," under the direction of Joe Ruzek and Patricia Watson (from the Executive Division). The most exciting new development is the establishment of an integrated clinic at Palo Alto that will permit us to test screening procedures as well as clinical outcomes from this delivery model. In addition, protocols will be tested for assessing resource and staffing needs so that VA administrators will be able to make accurate projections for supporting such integrated programs.

To summarize, I wish to commend Greg Leskin and other National Center staff who made our third conference on this theme such a success. They have all made a significant contribution to our growing momentum in this very important area. Hopefully, these efforts will lead to improved treatment for veterans throughout the VA system.





## EARLY INTERVENTION: A CLINICAL FORUM

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### Early intervention to prevent development of PTSD: Importance of post-trauma beliefs

One of the goals of early intervention is to ensure that trauma survivors are making sense of their experience and its implications in ways that are adaptive, stress-containing or reducing, balanced, and consistent with our knowledge of traumatic stress. In fact, much of existing practice in response to trauma survivors involves, in delivery contexts from rape crisis counseling to disaster mental health, the informal shaping of trauma-related beliefs, interpretations, and judgments. Education about trauma and its impact, the challenging of rape "myths", the "normalization" of acute stress reactions, and the instillation of hope for the future that feature in these settings all involve the belief system of the survivor and its impact on recovery.

This focus on beliefs is in fact consistent with much current thinking about traumatic stress. Many existing theories and therapies for PTSD attend to the role of trauma-related cognitive content in precipitating or maintaining trauma-related distress. For example, the cognitive model of PTSD proposed by Ehlers and Clark (1) posits that continuing negative appraisals of the trauma and its effects contribute to the persistence of PTSD by helping maintain a sense of ongoing threat.

Challenges in tackling trauma-related beliefs include the facts that such beliefs are specific to the individual and that there are many types of potentially important cognitions. For example, a given individual may be troubled by thoughts of personal guilt or shame, perceptions of a variety of negative future implications of the trauma, low perceived self-efficacy, distressing views of self (e.g., unworthy, weak, damaged, evil), and exaggeratedly negative judgments about other people or other aspects of the environment (e.g., others can't be trusted, dangerousness of the world). Cognitions about stress reactions themselves may also be important. The construct of anxiety sensitivity may be especially useful in this regard (2). Individuals who view their anxiety sensations as dangerous or otherwise harmful may respond poorly to the common post-trauma experiences of heightened arousal or panic.

One task of the helper is to assess for distressing thoughts and help the survivor rethink such thoughts in ways that correct mistaken understandings, place the situation in perspective, or simply soothe. However, relatively little is known about the best ways of identifying and challenging such beliefs in the contexts of early intervention. Several paper-and-pencil inventories are available to help assess trauma-related cognition, of which the Posttraumatic Cognitions Inventory (3) is perhaps the most comprehensive. Such inventories may be useful for identifying significant areas of cognitive content in the early aftermath of traumatization. In terms of intervention, while cognitive-processing therapy represents perhaps the most systematic and best validated approach to the restructuring of distressing trauma-related beliefs in those with PTSD (and has the virtue of being available in treatment manual format (4)), it has not been evaluated as an early intervention. As currently formulated, it is too intensive an intervention; preventive services will need to be deliverable in brief, cost-effective formats.

Many post-trauma efforts to influence interpretations of acute stress reactions, personal experience of trauma, and expectancies of the future are attempted via simple survivor education. The informal discussions that take place between trauma survivors and emergency mental health workers often address such content when it comes to light in conversation. Little is currently known about the utility of such helping conversations, or of the more formal didactic educational presentations that sometimes address these issues. Similarly, while the pamphlets and self-help materials available to survivors often directly or indirectly affect distressing beliefs, formal bibliotherapeutic interventions for trauma survivors have yet to be evaluated. The formal cognitive restructuring treatments (e.g., 5-7), while perhaps too time-consuming for most early intervention purposes, can probably be redesigned as moderate intensity (e.g., 2-5 session) interventions without a precipitous loss of impact. The relatively brief cognitive-behavioral "package" early intervention used successfully used to treat accident and assault survivors with acute stress disorder by Bryant and his colleagues (8), includes a significant cognitive restructuring component. It is likely that research will soon enable us to evaluate the relative impact of the cognitive restructuring component of such care.

At the current time, it is important that providers of early interventions attempt to identify distressing thoughts experienced by survivors and make them a focus of therapeutic efforts, whether through brief helping discussions, education, or more systematic multi-session efforts. Ways of doing this are likely to receive increasing attention in the coming years.

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# MATCHING TREATMENT RESOURCES TO PATIENT READINESS IN AN OUTPATIENT VA PTSD CLINIC

EVELYN SANDEEN, PH.D. & ELLA C. NYE, PH.D.



Evelyn Sandeen

At the New Mexico Veterans Health Care System (NMVHCS), our Trauma Clinic, like many others within the VA system, has been overwhelmed with the numbers of veterans being referred for services. At the same time, our staff has had the clear perception that some veterans are more ready for and able to make use of treatment than

are others. We have therefore felt the need for a rational triage system based

not on acuity as much as on patients' ability to benefit from intervention. In developing a model for a triage system, we have attempted to identify conceptual categories that may predict ability to benefit from treatment. We have looked to the research literature on readiness for treatment and treatment outcome. We have also identified some

some categories which highlight differences between VA trauma patients and civilian populations who have been traumatized, based on our assumption that there are some VA patients who are more like the non-VA patients who populate much of the effective trauma treatment literature (1). Identifying patients who can benefit from intensive treatment is critical, given the shortage of VA resources in the face of demand. Following are the categories that we investigate as part of an ongoing assessment designed to match patients to appropriate treatments:

**1. Comorbidity Issues** PTSD in general, and combat-related PTSD in particular, is often comorbid with multiple Axis I and Axis II disorders (2). It is important for patients to meet full DSM IV criteria for PTSD in order to benefit from trauma-focused interventions. There are many patients who have indeed survived trauma but for whom the post-trauma effects

are either not the highest treatment priority or are not best described by a PTSD diagnosis. Addressing primary diagnoses takes priority. An important related point is that having a trauma history does not imply that a veteran's difficulties are best conceptualized as PTSD, or that the veteran will benefit from services in a PTSD clinic. The sequelae of childhood

trauma, for instance, have been recognized to be frequently distinct from PTSD per se (3). Personality disordered veterans who have a trauma history but do not have PTSD, in our experience, are not helped significantly by the types of treatment we offer in our clinic.

A significant proportion of the dually diagnosed VA trauma patient population has substance use disorders in addition to PTSD. Both current literature (4), and our own experience suggest that substance use disorders must be addressed as a first priority in PTSD treatment. At the NMVAHS, we have established a close working relationship with the Substance Use Disorder (SUD) team, developing joint programs for veterans with both substance problems and PTSD. However,

there is a point at which, if the veteran is not working toward sobriety, we make the decision that he is not appropriate for further PTSD treatment. Patients who continue to abuse drugs or alcohol while in treatment for PTSD do not, in our experience, make lasting gains. Alcohol or drug abuse is an active avoidance strategy which is in direct contradiction to the treatment philosophy of most PTSD clinics. Additionally, failing to work on one's substance problem is a very good behavioral indicator of overall treatment motivation.

**2. Stability Issues** Combat veterans often live chaotic, potentially traumatic lifestyles, with high rates of homelessness, poverty, unemployment and violence (5). In our experience it is rarely core PTSD symptoms alone that bring patients to our emergency room or prompt them to call their provider in crisis, but rather factors such as substance use, chaotic relationships, violent behavior, or financial and housing difficulties. Veterans who present in crisis need crisis-oriented interventions



Ella C. Nye

**VA trauma clinics need a rational triage system to manage precious resources by identifying those characteristics that make trauma patients able to benefit from intensive staff time.**

## MATCHING TREATMENT RESOURCES

aimed at identifying and addressing the immediate causes of the crisis situation. These patients are clearly not ready to benefit from intensive trauma-focused therapies.

**3. Logistical Issues** Within the New Mexico VA system, we have many veterans who must travel great geographic distances to reach our clinic. We are beginning to work more closely with VA Community-Based Outpatient Clinics (CBOC's) and Vet Centers to provide better care to these veterans. It is important to be practical when undertaking treatment planning for such patients and define achievable treatment goals.

**4. Motivational Issues** VA trauma patients may have ambivalence toward improvement that is not present in non-VA populations. VA patients who are service-connected or are seeking service connection for their PTSD are in an inherent double-bind situation. There is legitimate fear that if they improve significantly their service-connected benefits will not be awarded or will be eliminated or reduced. Research suggests that accurate reporting of symptom levels is hurt by this situation (6). We suspect that improvement itself is negatively impacted as well. The reality of conflicting motivations for improvement is explored in an open and matter-of-fact way throughout treatment. While concern with service-connection is not seen as a rule-out for treatment, if motivation for symptom reduction is absent, no treatment gains are likely.

**5. Chronic Overt Anger** Higher levels of anger among veterans have been well documented (7). Because of the sometimes indefensible past treatment veterans have received from the military and/or from the VA, they understandably transfer some negative feelings onto current VA treatment providers. We find that working through some of this anger may be necessary to the early stages of the treatment process. However, high levels of anger continually expressed toward providers (rather than anger discussed with providers) hinders the effectiveness of treatment and bodes poorly for treatment progress (8).

**6. Patterns of Attachment** PTSD, like most psychiatric disorders, is often associated with insecure attachment styles (9). Patterns of attachment are central to an individual's ability to make use of forms of treatment which depend upon group process or the therapeutic relationship. We believe that much of our "clinical intuition" regarding a veteran's ability to benefit from these types of treatment is based on observations during the clinical interview that illuminate patterns of attachment. A veteran with PTSD who

demonstrates a secure pattern of attachment is able to express a clear valuing of relationships and interpersonal experiences while also being able to demonstrate apparent objectivity in the description and evaluations of particular relationships. Individuals vary in their ability to consistently demonstrate secure attachment, but those veterans unable to do so are unlikely to benefit from a therapy process that requires the ability to relate to others in non-rigid ways. These veterans may tolerate psycho-educational groups, but will probably not benefit from resource-rich process groups or short-term individual psychotherapies.

**7. Identity Issues** Unlike most rape victims or accident survivors, veterans who have been traumatized during their military service may present with a complex set of identity concerns around the role that produced their trauma. In addition to giving them lasting post-trauma symptoms, wartime experiences have given many veterans some of the most exciting and meaningful moments in their lives, as well as some of their most intense relationships with others. The veteran's ambivalence toward his military history sometimes makes him hostile to treatment interventions perceived as attempts to invalidate his experience. Given that the average age of a Vietnam combat soldier was 19, developmental identity issues were negatively impacted for many who participated in that conflict. Young soldiers severely traumatized before adult identity had fully formed may have been at increased risk of taking on dysfunctional identities such as "wounded PTSD Vet" to defend against other identities such as "killer", or the loss of identity. Some veterans have, as a result of their PTSD syndrome, led chaotic and/or substance-involved lives since their discharge from the military and have constructed an identity around that kind of lifestyle. They may be attached to seeing themselves as "rebels" or even "losers." All such dysfunctional identities may be threatened by active participation in treatment. We have found that group psycho-education can help some of these veterans begin to explore new identities. However, if resistance toward treatment remains high, such dysfunctionally-identified veterans will not be offered further psychotherapy within our system.

**8. Readiness for Change** We attempt to utilize the stages of change model (10) and gently push patients to identify whether they are ready to work and make changes in their lives. One practical way of doing this is to require homework from patients. Those who do not complete homework, and who are dismissive of the whole concept, are probably pre-contemplative and are not ready for change. These patients may benefit from interventions encouraging contemplation of change, but they are not good candidates for receiving intensive psychotherapeutic resources.

## SANDEEN &amp; NYE

**New Mexico Veterans Health Care System Trauma Clinic:  
Matching Patients To Appropriate Resource Intensity**

We have attempted to provide resource-rich therapies to patients who can make full use of them by having a graduated treatment model in which the first steps of treatment are relatively resource-efficient, such as orientation or psycho-educational classes. Ongoing assessment is based on the patient's response to early treatment interventions, including interest and engagement in the process, ability to self-disclose, ability to interact with others in ways that are not rigidly defensive, and

**....having a trauma history  
does not imply that a  
veteran will benefit from  
services in a PTSD clinic.**

ability to express emotions other than anger. Patients who demonstrate these behavioral markers of treatment readiness will be offered further, more resource-rich therapies such as exposure-based trauma processing. We have tried to eliminate treatment modes within our program that demand intensive staff time but require no work on the part of patients. We no longer offer drop-in "rap groups" because we found that such groups were a magnet for patients who wanted to access support, but were obviously pre-contemplative in regard to readiness for change. Patients who value support and a sense of belonging but are unable to participate in treatment are referred to veterans support groups in the community. We try to match the level of therapist involvement with the level of patient involvement.

Our program rests on the twin pillars of efficiency and effectiveness. Efficiency represents seeing as many patients as we can ethically and effectively treat, and treating patients for the minimum amount of time which will produce effective results. Efficiency also means management of personnel resources to achieve maximum payoff in terms of patient benefit. Effectiveness represents our commitment to treating patients using the best-researched and most powerful interventions we have. In addition to the research literature on treatment of PTSD, we also include our own program development data and clinical evaluations of what is effective in making choices about what interventions to use. As a result of this process, our clinic has focused on four main approaches to the treatment of trauma: psycho-education and support, psychiatric management, skills training, and exposure and cognitive therapies.

These approaches vary both in the intensity of resources they represent as well as in their ultimate potential for efficacy in treating PTSD. Psycho-education and support are relatively inexpensive interventions if kept time-limited, from which nearly every patient can benefit. Psychiatric management is moderately to highly effective for most of our patients, and represents a moderately expensive intervention. We have found skills-training to be helpful for patients who have completed some other form of intervention and have begun to enjoy some improvements in their lives as a result of treatment. Skills-training is relatively inexpensive, but only patients who have shown readiness for change are appropriate for this type of intervention. We see exposure-based and cognitive therapies as both the most expensive and the potentially most effective for those patients who are not ready or able to benefit from them for the reasons cited above. To achieve both efficiency and effectiveness, our clinic must utilize ongoing assessment to match patients to appropriate treatments.

In conclusion, we make the case that VA trauma clinics need a rational triage system to manage precious resources by identifying those characteristics that make trauma patients able to benefit from intensive staff time. We have identified several factors that contribute to the difficulties of a veteran with PTSD, only some of which are effectively addressed with research-validated trauma interventions such as exposure therapies and skills training. Individualized assessment and treatment planning are essential both for proper resource utilization and for truly helping patients. Finally, we believe that allocating the majority of staff time to those patients who are most able and ready to benefit is a key to preventing staff burnout.

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Funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System.

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